April 25, 2003 **REVISED**

David Martinez
TWCC Medical Dispute Resolution
4000 IH 35 South, MS 48
Austin, TX 78704

MDR Tracking #: M2 03 0857 01
IRO #: 5251

___ has been certified by the Texas Department of Insurance as an Independent Review Organization. The Texas Worker's Compensation Commission has assigned this case to ___ for independent review in accordance with TWCC Rule 133.308 which allows for medical dispute resolution by an IRO.

___ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, all relevant medical records and documentation utilized to make the adverse determination, along with any documentation and written information submitted, was reviewed.

This case was reviewed by a licensed Doctor of Chiropractic. The ___ health care professional has signed a certification statement stating that no known conflicts of interest exist between the reviewer and any of the treating doctors or providers or any of the doctors or providers who reviewed the case for a determination prior to the referral to ___ for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

CLINICAL HISTORY

This patient was injured in ___ while at work at an airport as a baggage handler. She was attempting to lift heavy luggage. Records indicate the luggage was in excess of 50 pounds. In lifting the bag, she had anticipated that it was much lighter and was caught off guard, causing an immediate onset of low back pain. She has had extensive care, indicated in the records available, to include chiropractic manipulation, passive and active care. MRI revealed bulges in the lower lumbar spine. Advanced treatment rendered includes Epidural Steroid Injections. A discogram confirmed positive findings at L2/3, L3/4 and L4/5. She was found to not be at MMI by designated doctor ___ MD in November of 2002. While surgical repair of the lumbar spine has been recommended by ___, no surgery has been performed at this time. ___ disagrees with a planned surgery and stated that he did not feel that a 3 or 4 level fusion would be successful. A Required Medical Examination was performed by ___ in November of 2001 which found MMI with 0% impairment and recommended return to work.

REQUESTED SERVICE

The carrier has denied the medical necessity of a LSO brace.

DECISION

The reviewer agrees with the prior adverse determination.

BASIS FOR THE DECISION

While objective evidence does exist that will indicate a lumbar pathology beyond doubt, the question to ask is whether such a treatment option is reasonable in this case. It is the opinion of the reviewer that restriction of lumbar motion is a contraindication to reconditioning, especially this late date post-injury. In the acute phase of a serious low back injury, one can make a case for such treatment. Even in a post surgical instance it is possible that a back brace would be helpful. However, in a chronic low back injury with degeneration there is no known science-based reference found to indicate that restriction of lumbar ROM is a reasonable protocol. As a result, I would find the treatment is not necessary to deal with this lady's condition.

___ has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. ___ has made no determinations regarding benefits available under the injured employee's policy.

As an officer of ___, I certify that there is no known conflict between the reviewer, ___ and/or any officer/employee of the IRO with any person or entity that is a party to the dispute.

___ is forwarding by mail and, in the case of time sensitive matters by facsimile, a copy of this finding to the treating doctor, payor and/or URA, patient and the TWCC.

Sincerely,

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the decision and has a right to request a hearing.

In the case of prospective ***spinal surgery*** decision, a request for a hearing must be made in writing and it must be received by the TWCC Chief Clerk of Proceedings within 10 days of your receipt of this decision. (20 Tex. Admin. Code 142.5(c)).

In the case of other ***prospective (preauthorization) medical necessity*** disputes a request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision (28 Tex. Admin. Code 148.3).

This decision is deemed received by you 5 (five) days after it was mailed (28 Tex. Admin. Code 102.4(h) or 102.5(d). A request for a hearing should be sent to: Chief Clerk of Proceedings, Texas Worker's Compensation Commission, P.O. Box 40669, Austin, TX 78704-0012. A copy of this decision should be attached to the request.

The party appealing this decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute, per TWCC rule 133.308(t)(2).

I hereby certify, in accordance with TWCC Rule 102.4 (h), that a copy of this Independent Review Organization decision was sent to the carrier, requestor, claimant (and/or the claimant's representative) and the TWCC via facsimile, U.S. Postal Service or both on this 25th day of April 2002.